DEPARTMENT: Clinical Services Group (CSG) Infection Prevention	**POLICY DESCRIPTION:** Infection Prevention NHSN Event Documentation Clarification Process
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EFFECTIVE DATE: November 3, 2025	**REFERENCE NUMBER:** COG.COM.005
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All personnel responsible for performing, supervising, and monitoring Infection Prevention abstraction and surveillance efforts and/or medical record documentation relative to Infection Prevention public reporting within HCA Healthcare affiliated facilities including, but not limited to, hospitals, hospital- based outpatient surgery departments, and all Corporate Departments, Groups and Divisions.

PURPOSE: The purpose of this policy is to establish processes to clarify incomplete or ambiguous documentation that will be used for Infection Prevention abstraction/infection surveillance. It also defines when an Infection Prevention query to a provider will be initiated and outlines the appropriate Infection Prevention query process to be utilized. It is not to be used for questions involving diagnosis or procedure codes as those are covered under REGS.DOC.002.

POLICY:

Appropriate querying will improve the accuracy, integrity, and quality of medical record documentation; minimize variation in the query process; and improve the quality of Provider documentation within the medical record. Company-affiliated facilities will follow appropriate processes to:

A. Initiate National Healthcare Safety Network (NHSN) hospital acquired infection (HAI) Case Clinical Clarification form (Appendix A) as appropriate when documentation in the medical record is illegible, incomplete, inconsistent, or unclear for Infection Prevention data abstraction. Submit a clinical clarification either concurrently or retrospectively.

B. Obtain documentation related to Infection Surveillance within the guidelines published in the current NHSN Patient Safety Component Manual and consistent with the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation.

   1. Per the Conditions of Participation, an addendum or late entry should be added to the medical record within 30 days of discharge. If this is done, it can be used as a data element to meet infection criteria.

   2. Per the CMS Medicare Program Integrity Manual, “All services provided to beneficiaries are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided may not be properly documented. In this scenario, the documentation may need to be amended, corrected, or entered after rendering the service. The date and author of any amendment, correction or delayed entry should be identifiable, and the change/addenda should be clearly and permanently denoted. Contractors shall review any amendment, correction, or delayed entry in accordance with section 3.3.2.4 of this chapter.”

   3. Per the CMS National Hospital Inpatient Quality Measures Specifications Manual, **“It is not the intent to have documentation added at the time of abstraction to ensure the passing of a measure.”**

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C. The operating room (OR) procedure record should be finalized within 3 days of the case procedure date. Once finalized, the case can be reopened for corrections for 4 additional days. Therefore, the documented wound class for a procedure cannot be updated more than 1 week from the procedure date without unintended consequences such as duplicate billing.

D. Reflect the patient's clinical course, care provided, and clinical decision making for the purpose of accurate Infection Prevention data abstraction/Infection Surveillance.

E. Ensure control processes are implemented to minimize potential compliance risks.

F. Improve the quality of the Provider documentation.

G. Align with other service lines with established policies and procedures for clinical clarification. See also COG.COM.001 Core Measure Clarification Process Documentation and Education policy.

PROCEDURE:

All efforts to clarify incomplete and/or ambiguous documentation as it relates to Infection Prevention data elements and abstraction/surveillance within the medical record (i.e., addendums, late entries) must be done utilizing the following process. The primary goal is to obtain accurate documentation that is representative of the care provided. **It is not the intent to have documentation added at the time of case review to ensure criteria for infection can be met.**

A. Infection Prevention Clinical Clarification Process

Facility Infection Preventionist responsible for reviewing and/or reporting HAI data must understand and adhere to the following requirements:

1. Infection Prevention clinical clarifications can be initiated either concurrently or retrospectively as an established mechanism of communication between an Infection Preventionist and Provider to clarify documentation in the medical record.
2. Infection Prevention clinical clarifications can be sought when the documentation of the clinical picture of the patient indicates an infection prevention element was considered, addressed, or a condition was present, but the Provider has not specifically or clearly documented the clinical indications, signs/symptoms, or decision-making process within the medical record.
3. The selection of the appropriate data element requiring clinical clarification will be determined based on the incomplete and/or ambiguous documentation.
4. Clinical clarifications may be discussed with the Provider via the clinical clarification form but will require that the provider make an official amendment to the medical record. No other means of communication will be acceptable as evidence to meet an infection definition element.

5. It is not acceptable for an Infection Preventionist to lead the Provider in any way, dictating what should or should not be written. The /Provider's clarification should reflect the actual clinical care and outcomes of the patient encounter.
6. The Infection Preventionist should not make repeated attempts to obtain clarification with the intent only to receive a particular outcome.
7. For clarifications involving surgical procedure codes, refer to the HIM Coding Prebill Account Review Tool (CPART) SharePoint Site.

   Per HCA Infection Prevention (IP) Clinical Services group (CSG), only publicly reported data must have coding reviews submitted for clarification. Any other coding reviews may be done at the Facility's discretion.
8. The Parallon Clinical Data Registry Abstraction (CDRA) Infection Prevention abstraction team may discuss incomplete or ambiguous documentation preventing a case from meeting a specific definition with the Infection Preventionist. The CDRA abstraction team cannot recommend an amendment to the medical record or give instructions or details on what would need to be documented to meet a definition.
9. When an amendment to the medical record is used as an element for data abstraction/ Infection Surveillance, the Infection Preventionist is to take "ownership" of the infection document, updating the infection case by changing the assignee to their name and updating the document in the electronic surveillance system, as appropriate, noting any new information the abstractor may not be aware of.

B. Response from the Provider

1. If the Provider agrees to the clinical clarification discussed with the Infection Preventionist, an official addendum/late entry should be made to the medical record following the CMS Conditions of Participation referenced above (section Policy Section #3) and pursuant to the Facility by-laws and rules for medical record documentation.
2. Per the NHSN manual requirements, amendments related to present at the time of surgery (PATOS) criteria must be associated with the full Operating Room procedure note.

C. Inclusion and Maintenance in the Permanent Medical Record

There may be instances when the Provider response is received outside the CMS Conditions of Participation referenced above (section Policy Section #3) and/or pursuant to the Facility by-laws and rules for medical record documentation. When this occurs, the update to the permanent medical record may still be made at the discretion of the Provider but will not be used for the purpose of Infection Prevention data abstraction/Infection Surveillance.

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D. Facility Responsibilities

Administration and medical staff must support this process to ensure its success. It is the responsibility of each Facility's administration to ensure that this policy is adhered to by all individuals involved in the clinical documentation of patient care.

E. Education and Tracking

1. All facilities should educate their Providers on the importance of clear, accurate, complete, and concurrent documentation within the body of the medical record.
2. Communication must be provided to the Providers that an Infection Preventionist might be initiating requests to support accurate and complete documentation in the medical record.
3. The Infection Control Committee (ICC) Chair, or designee, is responsible for holding the facility's Providers and Staff accountable for annual review and compliance with this policy and resource documents.
4. Clinical Clarification tracking and trending must be performed and trends assessed, at a minimum, on an annual basis to identify ongoing educational and documentation needs of the Providers and Staff.
5. The ICC Chair, or its designee, must provide verification to IP CSG, including their Divisional Lead IP (DLIP) of completion of annual review of the policy, tracking/trending data, and any educational actions needed to be taken.

F. Corporate Responsibilities

1. CSG Infection Prevention will review the tools and resources related to clinical clarifications as appropriate to include any regulatory requirements on at least an annual basis. New Hire mandatory education will be provided to facility personnel who are responsible for performing NHSN case event reviews, validation and/or reporting.
2. CSG Infection Prevention will monitor the participation and completion of the enterprise's new hire mandatory education.

G. Questions and Concerns related to the Infection Prevention Clinical Clarification Process

1. All day-to-day operational issues should be handled locally at the Facility working collaboratively with one's direct supervisor and/or Facility Ethics and Compliance Officer.
2. For unresolved or unanswered general questions regarding operations or implementation of the COG.COM policies, please contact the CSG IP group at CorpIP@HCAHealthcare.com.

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3. Each colleague has an individual responsibility for reporting any activity by any colleague, physician, subcontractor, or vendor that appears to violate applicable laws, rules, regulations, accreditation standards, standards of medical practice, Federal healthcare conditions of participation, or the HCA Healthcare Code of Conduct.
4. If a matter that poses serious compliance risk to the organization is reported locally, and if the reporting individual doubts that the issue has been given sufficient or appropriate attention, the individual should report the matter to higher levels of management or the Ethics Line until satisfied that the full importance of the matter has been recognized.

DEFINITIONS:

Clinical Clarification Process is an established mechanism of communication between a Facility Infection Preventionist and Clinical Staff to clarify incomplete and/or ambiguous documentation in the medical record that will be used for the purpose of Infection Prevention data abstraction/Infection Surveillance, such as the use of addendums or late entries.

Providers are Physicians, Advanced Practice Nurses, Physician Assistants, Certified Registered Nurse Anesthetists, Nurse Practitioners, Licensed Independent Practitioners, and Nurse Midwives.

Infection Prevention Abstractors include all individuals responsible for performing, supervising, or monitoring Clinical Registry Data Abstraction (CDRA) Infection Prevention (IP) data abstraction and/or case review, validation, compliance monitoring, and other activities involved in ensuring facilities accurately report required publicly reportable infection surveillance data.

REFERENCES:

1. Regulatory Compliance and Support SharePoint Site:
   - Core Measure Clarification Process Documentation and Education, COG.COM.001
   - Documentation Improvement (DI) – Compliance Requirements Policy, REGS.DOC.001
   - Query Documentation for Clinical Documentation Improvement (CDI) & Coding – Compliance Requirements, REGS.DOC.002
2. CSG Infection Prevention Sharepoint Site
   - Clinical Reporting Policy, COG.COM.004
3. National Healthcare Safety Network (NHSN)
   - Patient Safety Component (PSC) Manual
   - CDC/CMS Joint Reminder on NHSN Reporting
4. The Medicare Conditions of Participation for Medical Records, 42CFR482.24(c)(4)(viii)
5. CMS “Medicare Program Integrity Manual” Chapter 3, Section 3.3.2.5.

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6. CMS National Hospital Inpatient Quality Measures, Specifications Manual, Section 1: Data Dictionary, Medical Record Documentation, pg. 1-4.
7. Clinical Data & Registry Abstraction (CDRA) Documentation Clarification Policy & Procedure PARA.HSC.CDRA.17